United States Court of Appeals

for the Second Circuit

BRIEF FOR APPELLANT

76-7187

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P/S

UNITED STATES COURT OF APPEALS
SECOND CIRCUIT

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RUTH FRIEDMAN, RAYMOND FRANKLIN, SIDNEY MOHR, WILLIAM C. LINGARD, AND CHIAM PEIMER, individually and on behalf of all other persons similarly situated, :

Plaintiffs-Appellants,

-against- :

STEPHEN BERGER, individually and as Commissioner of the New York State Department of Social Services, THE NEW YORK STATE DEPARTMENT OF SOCIAL SERVICES, JAMES DUMPSON, individually and as Commissioner of the New York City Department of Social Services, and THE NEW YORK CITY DEPARTMENT OF SOCIAL SERVICES, :

Defendants-Appellees. :

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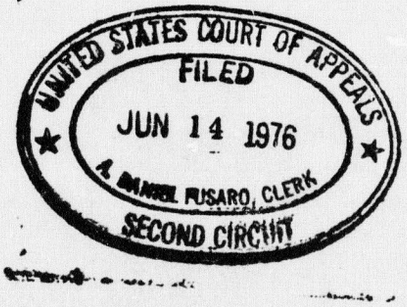
BRIEF FOR PLAINTIFFS-APPELLANTS



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PRELIMINARY STATEMENT

This is an appeal from an order and judgment of Judge Inzer B. Wyatt of the United States District Court of the Southern District of New York, dated March 17, 1976. It has not been reported.

STATEMENT OF THE ISSUES

1. Under the Social Security Act, can New York require institutionalized recipients of federal Supplemental Security Income benefits to spend on medical bills all of their income over $28.50 a month to qualify for medical assistance?

2. Under the Social Security Act, can New York State require institutionalized recipients of medical assistance to spend so much of their income on medical expenses that they have left less income for personal expenses than a comparable recipient of cash public assistance?

3. Under the Social Security Act, can New York State refuse to allow institutionalized recipients of medical assistance a $20 a month income disregard in calculating the amount of medical assistance they can receive?

4. Did the district court have any proper basis for denying class certification?

STATEMENT OF THE CASE

This is an action pursuant to 42 U.S.C. §1983 challenging a regulation of the New York State Department of Social Services, 18 N.Y.C.R.R. §360.5(e), which limits the net available income of plaintiffs-appellants (hereinafter "plaintiffs") and their class to $28.50 per month. Plaintiffs are disabled persons receiving treatment for chronic diseases in medical institutions and intermediate care facilities, such as nursing homes. Because they have some income, they do not receive cash public assistance, but they are eligible for medical assistance ("Medicaid") because they are disabled and because their medical expenses exceed their income.

Under 18 N.Y.C.R.R. §360.5 plaintiffs are required to utilize for medical expenses ("spend down") all but $28.50 of their income to be eligible for Medicaid. They have available to them only $28.50 per month for all personal expenses. Plaintiffs contend that the $28.50 limitation in 18 N.Y.C.R.R. §360.5(e) violates the Social Security Act, 42 U.S.C. §§1396a(a)(14), (17), binding regulations of the United States Department of Health, Education and Welfare ("H.E.W."), and the equal protection and due process clauses of the fourteenth amendment.

By order to show cause dated January 26, 1976 plaintiffs moved for a preliminary injunction against defendants' enforcement of the $28.50 limitation in 18 N.Y.C.R.R. §360.5(e) on the ground that it

violated the Social Security Act and H. E. W. regulations, and for an order certifying this as a class action. In a memorandum and order dated March 17, 1976, Judge Inzer B. Wyatt dismissed the complaint and refused to certify the action as a class action. Subsequently plaintiffs moved for reargument and reconsideration of the memorandum and order of March 17, 1976. This motion was denied by order dated April 9, 1976. Plaintiffs then appealed to this Court.

By order dated April 14, 1976 the district court gave plaintiffs permission to proceed on this appeal in forma pauperis. By order dated May 7, 1976, this Court gave plaintiffs leave to dispense with an appendix provided they filed three copies of the parts of the record on which they rely.

STATEMENT OF FACTS

The great majority of people in chronic care hospitals and nursing homes are unable to pay the staggering charges of these institutions. Even people who have substantial savings when they enter an institution soon find their money exhausted. For this reason, chronic care patients in New York almost invariably become recipients of Medicaid under Title XIX of the Social Security Act, 42 U.S.C. §1396 et seq., in order to pay part or all of the cost of their care. The Medicaid program is jointly funded by the federal government and the State. It is administered in New York under New York Social Services Law §363 et seq. by the New York State Department of Social Services and local departments of social services, including the New York City Department of Social Services. In return for the millions of dollars a year in Medicaid money New York receives from the United States, it must operate its program in conformity with the Social Security Act ("the Act") and H.E.W. regulations.

Chronic care petients can qualify for Medicaid in two ways under the Act and New York law. The first classification is the so-called "categorically needy". These are patients who receive cash public assistance. They are automatically eligible for Medicaid. 42 U.S.C. §1396a(a)(10). The cash public assistance program for single adults (either in or outside of chronic care institutions) is the federal

Supplemental Security Income ("SSI") program, 42 U.S.C. §1381 et seq. To qualify for SSI benefits a person must be aged, blind, or disabled and must meet an income eligibility standard. All patients in chronic care facilities are disabled, so that criterion presents no issue here. In general, to be financially eligible for SSI a person must have income of less than $146 a month.* 42 U.S.C. §1382(a)(1). Because in-patients in chronic care facilities have their housing and food expenses covered by their medical assistance benefits, however, the Act, 42 U.S.C. §1382(e)(1), establishes a separate eligibility standard for institutionalized persons, $300 a year or $25 a month. See 20 C.F.R. §416.231(a)(2).

Both SSI income eligibility standards are complicated by the Act's requirement that, in calculating a person's eligibility, the first $240 a year or $20 a month of income must be "disregarded." **

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* Many states, including New York, have created supplementary programs for the aged, blind, and disabled paid for out of their own funds. These supplementary programs in effect raise the SSI eligibility level for persons in those States. But this supplementation is not given to chronic care patients in New York and is irrelevant here.

** The "$20 disregard" does not apply to income paid on the basis of need (that is, other welfare benefits), but none of the income of plaintiffs referred to herein is paid on the basis of need and therefore this limitation is not relevant to this case.

U.S.C. §1382a(b)(2). Thus an institutionalized person is eligible for cash SSI benefits if his income is less than $45 a month ($25 in benefits plus the $20 in disregarded income). He is not eligible for SSI benefits if his monthly income is $45 or more.

Even if a chronic care patient is not "categorically needy," he may still be eligible for Medicaid if he falls into the second classification, the "medically needy." A person is "medically needy" if he is (1) eligible for SSI benefits except for his income (that is, if he is aged, blind, or disabled); and (2) if he lacks sufficient income to meet his necessary medical expenses. 42 U.S.C. §1396a(a)(10)(C)(i); 45 C.F.R. §248.1(a)(2)(i). Plaintiffs and their class are all medically needy because they are disabled and because they have income of more than $45 a month but less than the amount necessary to pay their high medical expenses.

To receive medical assistance, a medically needy person is required to use for medical expenses his "excess" income above a specified level.* This process is known as "spending down."

The question presented by this case is the following: to what level New York may require medically needy chronic care patients to spend down, or, put another way, how much of their income must chronic

*This level should be no lower than the equivalent cash public assistance level; see 42 U.S.C. §1396 U.S.C. §1396a(a)(17) and discussion in Point I, A, infra.

care patients be allowed to retain to cover their personal expenses? The regulation challenged here, 18 N.Y.C.R.R. §360.5(e), sets the level at $28.50. Plaintiffs contend that the Social Security Act requires that they be allowed to keep at least $45.

The personal expense allowance is of critical importance to plaintiffs, because none of their normal living expenses, except room, board, and medical care, are covered by their medical assistance benefits or their institutions. Out of their personal expense allowances plaintiffs must pay for, among other things, clothing, shoes, shaving items, toothpaste and other toiletries, news papers and other reading material, cigarettes, candy, telephone calls, transportation, and dry cleaning. Since $28.50 a month is grossly inadequate to cover all these expenses, plaintiffs, some of whom, like William C. Lingard, have outside income of more than $500 a month, must do without many common necessities and small comforts of life. Like Mr. Lingard, they must make do with ancient clothing. Like Ruth Friedman and Raymond Franklin, they must forgo buying a daily newspaper because this would cost them more than one quarter of their net income. In addition, plaintiffs are often cut off from the outside world by their financial situation even more than by their physical condition. Mrs. Friedman cannot afford to telephone one son in Massachusetts or to visit another son in Brooklyn. Chaim Peimer cannot even travel to the Jewish Braille Institute to tape books for the blind.

ARGUMENT

POINT I

THE DISTRICT COURT ERRED IN DISMISSING THE COMPLAINT

18 N.Y.C.R.R. §360.5(e) provides in relevant part that

> "If an applicant or recipient [of Medicaid] is receiving chronic care in a medical institution or intermediate care facility, all resources in excess of those exempt from consideration in accordance with paragraph (a) of subdivision 2 of section 366 of the Social Services Law and $28.50 per month for personal expenses shall be utilized to meet the cost of medical assistance for such applicant or recipient..."

The resources exempt from consideration under Social Services Law §366(2)(a) are certain property and specified income for the support of family members outside institutions. These resources are not involved in this case. Plaintiffs and their class are thus left with net income of $28.50 a month.

Plaintiffs contend that the $28.50 limitation violates at least two aspects of the Social Security Act, 42 U.S.C. §1396a(a)(17), and implementing H.E.W. regulations: (1) it requires plaintiffs to spend down below the level of income of cash public assistance recipients, in violation of the requirement that a state maintain "comparable" eligibility standards for the categorically needy and the medically needy; and (2) it denies plaintiffs the benefit of the

$20 income disregard which the Act provides them.

A. 18 N.Y.C.R.R. §360.5(e) Violates the Social Security Act and H.E.W. Regulations By Limiting Plaintiffs to A Net Income Below Public Assistance Level.

The Social Security Act, 42 U.S.C. §1396a(a)(17), provides, inter alia, that the state plan of a state participating in the Medicaid program shall

> "include reasonable standards (which shall be comparable for all groups and may, in accordance with standards prescribed by the Secretary, differ with respect to income levels, but only in the case of applicants or recipients of assistance of this plan who are not receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, XVI or part A of subchapter IV of this chapter, and with respect to whom supplemental security income benefits are not being paid under sub-chapter XVI of this chapter based on the variations between shelter costs in urban areas and in rural areas) for determining eligibility for and the extent of medical assistance under the plan..." (Emphasis added).

The Act's requirement of comparability of standards for "eligibility for and extent of medical assistance" means that the medically needy may not be required to spend down below the income level of cash recipients.*

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* The exception to the comparability requirement in 42 U.S.C. §1396a(a)(17) for certain situations involving "variations between shelter costs in urban areas and in rural areas" is not applicable to this case.

This is confirmed both by the more specific requirements of implementing H.E.W. regulations and by caselaw. Title 45 C.F.R. §248.3(c), provides that

> "With respect to the medically needy, the State plan must:
>
> (1) Provide levels of income and resources for maintenance, in total dollar amounts, as a basis for establishing financial eligibility for medical assistance. Under this requirement:...
>
> (ii) Except as specified in paragraph (c)(2)(iii) of this section, the income levels for maintenance must be, as a minimum, at the higher of the levels of the payment standards generally used as a measure of financial eligibility in the money payment programs, that is...
>
> (B) In the case of individuals...
>
> (2) The highest level of payment which is generally available to any individuals in any of the three groups (aged, blind, and disabled) who are (or would be, except for income) eligible for benefits under title XIX." *
> (Emphasis added).

The "highest level of payment which is generally available to any individuals in any of the three groups (aged, blind, and disabled)..." is that provided by the SSI program. An institutionalized SSI recipient receives up to $25 a month in cash benefits under 42 U.S.C. §1382 (e)(1)(B) and 20 C.F.R. §416.231(a)(2). In addition, an SSI recipient is entitled to an income disregard of $20 a month under 42 U.S.C. §§1382a(b):

*The exception to the requirement of this section contained in §248.3(c)(1)(iii) involves a special situation not relevant to plaintiffs or their class.

> "In determining the income of an individual... there shall be excluded--...(2) the first $240 per year (or proportionately smaller amounts for shorter periods) of income (whether earned or unearned) other than income which is paid on the basis of the need of the eligible individual."

Thus an institutionalized SSI recipient is entitled to keep up to $45 a month for his personal expenses.* Since plaintiffs and their class all have income of more than $20 per month, under the comparability requirements of 42 U.S.C. §1396a(a)(17) and 45 C.F.R. §248.3(c), plaintiffs must also be allowed to keep at least the same $45 for personal expenses a categorically eligible patient would receive.

The courts have applied the comparability requirements strictly in cases analogous to this one to insure that the medically needy are not forced to live at a level of income or resources below that allowed

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*There has been a question in this case whether chronic care patients in New York who receive SSI benefits are, in fact, permitted to keep $45. The district court found that categorically needy persons were not entitled to keep $45, Memorandum and order dated March 17, 1976 (hereinafter "Slip Opinion"), R-34, although the court said it was possible that New York officials were mistakenly allowing the categorically needy do so. Slip Opinion, R-35. Plaintiffs argue that categorically needy patients are entitled to keep up to $45 but will concede that the categorically are, in fact, normally prevented from keeping more than $28.50 by New York officials. See Point I, B, infra.

recipients of cash assistance. In Aitchison v. Berger, 404 F. Supp. 1137 (S.D.N.Y. 1975), aff'd, No. 75-7673 (2d Cir. Feb. 13, 1976), cert. petition filed, No. 75-1447, stay denied (U.S. Apr. 19, 1976), this Court recently affirmed a decision holding that under 45 C.F.R. §248.3 New York could not require some medically needy families to live below the level of cash assistance payable to a similar family. The dispute in Aitchison arose because the New York Social Services Law §131-a provides a basic assistance grant plus the actual rent paid (up to a limit). For Medicaid purposes, New York created a separate standard consisting of the basic grant plus a flat amount for rent, which the State asserted was the average rent. The effect of averaging was that families with above average rent had to spend down to below the level of assistance they could have received if they had been cash recipients. This Court found that New York scheme violated the federal regulation. See also Schlemowitz v. Lavine, 75 Misc.2d 529, 348 N.Y.S.2d 473 (Sup. Ct. Nassau Co. 1973).

In another recent case, Brown v. Beal, 404 F. Supp. 770 (E.D. Pa. 1975), the court found the comparability requirement violated in two respects. The Pennsylvania scheme required the medically needy to spend down to the level of federal SSI assistance, and thus denied them the benefit of Pennsylvania's $20 a month supplementation of the federal SSI benefits. In addition, Pennsylvania required the medically needy, but not cash SSI recipients, to pay for prescription drugs.

The necessity of buying drugs forced the medically needy even farther below the level of cash recipients. The Court found that both these aspects of the Pennsylvania program violated the comparability requirement.

In Dominguez v. Milliken, CCH Medicare and Medicaid Guide Par. 26, 633 (W.D. Mich. 1973), the court found that a Michigan rule which allowed the medically needy $20 less a month in disregarded income than the cash payment standard violated the comparability requirement. In Schaak v. Schmidt, 344 F. Supp. 99 (E.D. Wisc. 1971), the comparability requirement was held to invalidate a provision allowing the medically needy a homestead exemption less liberal than that applied in cash assistance programs.

The facts of the present case are even more extreme than those of any of the previous cases. 18 N.Y.C.R.R. §360.5(e) allows plaintiffs net protected income of only about 63% of the relevant cash assistance standard. 18 N.Y.C.R.R. §360.5(e) thus clearly violates 42 U.S.C. §1396a(a)(17) and 45 C.F.R. §248.3(c) and all the cases interpreting those sections.

B. The District Court Erred in Holding That Categorically Needy SSI Recipients Could Be Required To Spend Down to $28.50

The district court did not deal directly with plaintiff's comparability argument but instead found that any possible comparability requirement was met because both the categorically needy and the medically needy were required to spend down to $28.50 and thus comparable standards were applied to both. Slip Opinion, R-31 - R-32, R-34. The district court did not deny that SSI recipients received up to $45 income but said that when they received more than $28.50, New York could require them to spend the "excess" on their medical care as a condition of their receiving Medicaid. Slip Opinion, R-34.

This finding conflicts directly with the Act, which specifically provides that a recipient of SSI cannot be required to pay any fee or portion of his medical expenses as a condition of his receipt of Medicaid. 42 U.S.C. §1396a (a)(14) provides in relevant part that a State plan for medical assistance shall

"effective January 1, 1973 provide that -

(A) in the case of individuals... with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter...

(1) no enrollment fee, premium, or similar charge, and no deduction, cost sharing, or similar charge with respect to the care and services listed in clauses (1) through (5) and (7) of Section 1396d (a) of this title will be imposed under the plan..."

The medical services listed in clauses (1) through (5) and (7) of section 1396d (a) include the services being provided to plaintiffs: in-patient hospital services [§1396d (a) (1)] and skilled nursing facility services [§1396a (a)(4)(A)]. The clear import of §1396a (a)(14) is that the categorically needy are entitled to Medicaid at no cost to them and that they cannot be required by New York State to spend down to $28.50 under 18 N.Y.C.R.R. §360.5(e) to be eligible for medical assistance.

Nevertheless, New York contends that its practice of requiring categorically needy chronic care patients to spend down is legal because it has been approved by H.E.W. H.E.W. has apparently granted its approval. H.E.W.'s Policy Information Memo No. 74-11 (R-47), relied on by defendants, states on its first page that "there is currently no prohibition against applying income which is disregarded in the eligibility determination toward such cost [of care], as long as

the appropriate amount is retained for personal needs per CFR 248.3 (b) (4)[at least $25]." In other words, the categorically needy can be required to spend down to $25 and to forfeit the benefit of the $20 disregard.

The difficulty with H.E.W.'s position is that it too conflicts with the clear language of the Act prohibiting any "deduction, cost sharing, or similar charge" for any SSI recipient. 42 U.S.C. §1396a (a)(14). The H.E.W. memo relied on by defendants does not deny, as it could not, that the spend down requirement is a form of "cost sharing." Furthermore the memo apparently recognizes that its position conflicts with the language of the Act because it asserts on its third page (R-49) that "application of an institutionalized individual's income above the lower maintenance level toward the cost of care in the facility is not in conflict with the purpose or intent of limitations on cost-sharing." (Emphasis added.) The only purpose of the cost-sharing prohibition which is referred to in the H.E.W. memo is "to assure that the State-established maintenance standard necessary to meet expenses of living was protected for such individuals [public assistance recipients]." (R-48- R-49). But this logical and proper goal is just as applicable to chronic care patients as to non-institutionalized SSI recipients. In fact, because an institutionalized person has a lower basic maintenance level than a person on the outside, the in-patient needs protection against cost sharing even more than an out-

patient. A uniform cost-sharing requirement would take a higher percentage of the chronic care patient's personal expense allowance than of the non-institutionalized person's benefits.

Although not clearly expressed in the H. E. W. memo, the real purpose of H. E. W. 's attempt to evade the cost-sharing prohibition may be to deny institutionalized persons indirectly the benefit of the $20 disregard which is provided to them by 42 U. S. C. §1382a (b)(2). The $20 disregard is a higher percentage of the basic federal monthly grant for an institutionalized person ($25) than for non-institutionalized person ($146) and H. E. W. may consider this undesirable. Even this doubtful rationale, however, would at most justify a lower disregard for those in chronic care, not the effective elimination of any disregard, as under present H. E. W. policy. In any event, if H. E. W. feels the income disregard should be lower for in-patients than for others, this goal should be accomplished by an amendment to the Social Security Act, not by refusal to apply the unambiguous language of the Act as it is now written. Although H. E. W. 's interpretation of the Act is entitled to some weight, its interpretation cannot stand where, as here, it conflicts directly with the Act itself. See, e. g., NWRO v. Weinberger, 377 F. Supp. 861 (D. D. C. 1974); Bass v. Richardson, 338 F. Supp. 478 (S. D. N. Y. 1971).

Since the district court's finding that New York may legally require categorically needy chronic care patients to spend down from $45 to $28.50 conflicts with the Act's prohibition of cost-sharing, 42 U.S.C. §1396a (a)(14), and is thus ineffective, the contention of the medically needy plaintiffs that the comparability requirement of 41 U.S.C. §1396a (a)(17) means that they should be allowed the same $45 the categorically needy are entitled to has a solid logical foundation.* For all the reasons supporting plaintiffs' comparability claim set forth in Point I, A of this brief, the district court erred in dismissing it and the lower court decision should be reversed.

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* Although defendants did not so contend below, it might be thought that the provisions of 42 U.S.C. §1396a (a)(14)(B), which allow enrollment fees and nominal costs sharing for the medically needy, could justify a spend down for them not imposed on the categorically needy. This theory would be incorrect for several reasons. First, any enrollment fee or cost-sharing is paid out of a patient's income before the spend down process takes place. 45 C.F.R. §248.3(c)(2). Thus the fee or cost-sharing would precede the spending down process and would not change plaintiffs' factual or legal position here. Second, the enrollment fee or cost-sharing could not, in any case, require the recipient to go below public assistance level. 42 U.S.C. §1396a (a) (17). Third, any cost-sharing for the institutionalized would be limited to a small one-time only payment. 45 C.F.R. §§249.40 (a) (3) (v) and 249.40 (a) (3) (ii). Thus cost-sharing would apply only at the time of a patient's admission and could not affect a patient subsequently. For all these reasons any enrollment fee or cost-sharing could not affect plaintiffs' rights in this case.

C. Medically Needy Chronic Care Patients Are Entitled to a $20 a Month Income Disregard In Calculating The Extent of Their Medical Assistance And Personal Expense Allowances

In addition to violating the comparability requirement, 18 N.Y.C.R.R. §360.5(e) also conflicts with specific requirements of the Act and H.E.W. regulations that plaintiffs, like all other aged, blind and disabled persons, receive the benefit of a $20 a month income disregard in calculating how much medical assistance they will receive (and thus how much net income for personal expenses they will be allowed to retain). 18 N.Y.C.R.R. §360.5(e) allows plaintiffs no income disregard.

The Social Security Act, 42 U.S.C. §1396a (a)(17) requires, inter alia, that the state plan of a state participating in the Medicaid program

> "include reasonable standards...for determining eligibility for and the extent of medical assistance under the plan which ... (B) provide for taking into account only such income and resources as are, as determined in accordance with standards prescribed by the Secretary, available to the applicant or recipient and (in the case of any applicant or recipient who would, except for income and resources be eligible...to have paid with respect to him supplemental security income under subchapter XVI of this chapter [)] as would not be disregarded...in deter-

mining his eligibility for such aid, assistance or benefits..." (Emphasis added).

Plaintiffs are persons who would "except for income and resources be eligible...to have paid with respect to [them] supplemental security income under subchapter XVI..." "Subchapter XVI", 42 U.S.C. §1382a (b) (2), provides a $20 a month income disregard. Since plaintiffs would be entitled to an income disregard of $20 a month in calculating their eligibility for SSI, they are also entitled to that disregard in calculating their "eligibility for and extent of medical assistance" under 42 U.S.C. §1396a (a) (17).*

The same is true under H.E.W. regulations. 45 C.F.R. §248.3(c) states that

> "[w]ith respect to the medically needy, ...(3)...[i]n considering all income and resources when establishing eligibility, the State plan must provide for: ...
> (ii) In the case of the aged, blind or disabled, the highest of:
> (A) The disregards applied in title XVI..."

* Since New York's maintenance level is $28.50, granting plaintiffs a $20 disregard would allow them to keep $48.50 a month for personal expenses rather than $45. However, New York could, consistent with federal law, lower its maintenance level to $25 and thus reduce plaintiffs' net income for personal expenses to $45. 45 C.F.R. §248.3 (b) (4).

The district court did not deal separately with plaintiffs' claim to a $20 disregard but merely lumped it with the comparability argument. Slip Opinion, R-33 - R-34. Although the two claims are based on closely related aspects of the Act, 42 U.S.C. §1396a (a) (17), they merit separate attention.

H.E.W.'s position with respect to the applicability of the $20 disregard to medically needy chronic care patients is parallel to its view of the cost-sharing prohibition for the categorically needy. See Point I, B, supra. H.E.W. says that the statute and regulation requiring that the institutionalized medically needy be given the $20 income disregard, 42 U.S.C. §1396a (a) (17) and 45 C.F.R. §248.3 (c) (3) (ii), apply only to determinations of financial eligibility and that, after eligibility is established, the disregard is without effect in determining, pursuant to 45 C.F.R. §§248.3 (b) (4) and (5), the amount of net income for personal expenses which the "medically needy" can retain. See correspondence, Elmer Smith to John C. Gray, Jr. (R-23 - R-24).

H. E. W. 's claim that the $20 disregard is applicable in calculating eligibility for medical assistance, but not in figuring the amount of medical assistance a person receives is inconsistent with its own regulations, with the general scheme of the Social Security Act, and with the specific provision of the Act dealing with the $20 disregard.

First, H. E. W. 's interpretation of its regulations is inconsistent with their language. 45 C. F. R. §248.3 (c)(3), which applies the $20 disregard to the medically needy, requires that the state plan "Provide that all income and resources will be considered in establishing eligibility, and for the flexible application of income to medical costs not in the plan, and for payment toward the medical assistance costs." (Emphasis added). Thus the section clearly controls not only determinations of eligibility but also determinations of how much "payment towards the medical assistance costs" is to be required.

Second, the separate calculations of eligibility for and amount of assistance are inconsistent with the entire scheme of the Social Security Act. H. E. W. itself admits in its letter (R-24) that its interpretation of its regulations on institutionalized persons is

> "the only exception to the general rule of protection of disregarded income, i. e., any income which is disregarded in order to determine financial eligibility is not considered in the computing the liability of medical costs of persons who must 'spend down' to become eligible."

As the letter admits, this separation of the calculation of eligibility for and amount of assistance is unique. It applies only to institutionalized persons in a spend down situation and not other persons who spend down. That is, a medically needy person not in an institution is given the benefit of the disregard. The separation appears in no other aspect of the federally-assisted welfare programs under the Social Security Act and H. E. W. regulations: in every other situation eligibility for and extent of assistance are determined by the same standard, as common sense would require that they shoud be.

Third, even if H. E. W. 's interpretation of its regulations were consistent with their language, it would not control this case because it violates the unambiguous language of the Act itself.

42 U. S. C §1396a (a)(17) requires

> "standards for determining eligibility for and the extent of medical assistance under the plan which ... provide for taking into account only such income and resources as are ...available to the applicant or recipient and...as would not be disregarded...in determining his eligibility for such aid, assistance, or benefits." (Emphasis added).

The Act requires the application of the disregard in determining "extent of" as well as "eligibility for" medical assistance, in direct contradiction of H. E. W. 's interpretation. In the context of this case, the Act's reference to "extent of" assistance can mean nothing other

than the amount of medical assistance provided. And the amount of medical assistance provided necessarily determines the amount of personal expense money left to the recipient. H.E.W.'s interpretation of the Act would make the "extent of" assistance language a nullity.

As in the case of H.E.W.'s theory of the inapplicability of the cost-sharing prohibition in 42 U.S.C. §1396a(a)(14) to institutionalized persons, H.E.W.'s internally contradictory interpretation of the $20 disregard requirement is explainable only in terms of a desire to deny the benefit of the disregard to the institutionalized. Whatever the dubious social merits of this goal, it lacks any justification in the Social Security Act, which unambiguously requires that all medically needy persons be allowed the benefit of the $20 disregard in determining both their eligibility for Medicaid and the amount of assistance they should receive.

For all these reasons, the district court's order dismissing plaintiffs' claim to the $20 disregard should be reversed. Since there are no disputed issues of fact, the district court should be directed, on remand, to enter summary judgment for plaintiffs.

POINT II

THE DISTRICT COURT ERRED IN REFUSING TO CERTIFY THIS AS A CLASS ACTION

Plaintiffs brought this action on behalf of themselves and all other institutionalized medically needy recipients of Medicaid, that is, those who, because they have incomes of more than $45 a month, are not eligible for cash SSI benefits. Slip Opinion, R-32. In its decision, the Court said that plaintiffs' definition of the class was without legal significance because a person with income of up to $146 per month is eligible for SSI benefits. Slip Opinion, R-32. The Court denied class certification "for this reason (and there are other reasons)..." The Court's stated rationale for denying class certification is mistaken. Although the general standard for SSI income eligibility is indeed $146 a month, there is an express exception for institutionalized persons. The Act, 42 U.S.C. §1382(e)(1), provides than an institutionalized person is not eligible for SSI if he has income of more than $300 a year or $25 a month. See also 20 C.F.R. §416.231(a)(2). Since an SSI recipient is also entitled to an income disregard of $20 a month, 42 U.S.C. §1382a(b)(2), a recipient could have an income of up to $45 a month and be eligible for cash assistance. But an institutionalized person with more than $45 a month income is not eligible for SSI benefits. Thus plaintiffs accurately defined their class to include all

medically needy institutionalized recipients of Medicaid.

Nor is there any other basis for denying class recognition. The class alleged meets the four prequisites set forth in Rule 23 (a). It is undisputed that the class includes thousands of persons and there can be no doubt that it would be impracticable to join such numbers. See, e.g., Korn v. Franchard Corp., 456 F. 2d 1206, 1209 (2d Cir. 1972). There are issues of law or fact common to the class: each class member has the identical claims against the legality of the $28.50 income limitation in 18 N.Y.C.R.R. §360.5 (e). Named plaintiffs' claims are typical of the claims of the class since the claims of all members of the class are legally identical. And the named plaintiffs will fairly and adequately protect the interests of the class. There are no conflicts of interest amount members of the class known to plaintiffs; and plaintiffs are represented by attorneys for a Legal Services Corporation experienced in public assistance litigation who are vigorously pressing the claims of the class.

The alleged class also meets the standard of Rule 23 (b)(2) which makes available class relief when:

> "The party opposing the class has acted or refused to act on grounds generally applicable to the class, thereby making appropriate final injunctive relief or corresponding declaratory relief with respect to the class as a whole."

Like Aitchison v. Berger, supra, 404 F. Supp. at 1143, this is "a classic case for treatment as a class action under Fed. R. Cir. P. 23 (b)(2)." This action follows in a long line of class actions brought challenging state public assistance laws and regulations on the ground that they violate federal statutes and regulations and the Constitution. See, e.g., Rosado v. Wyman, 437 F. 2d 619 (2d Cir. 1970), aff'd, 402 U.S. 991 (1971); Boddie v. Wyman, 434 F. 2d 1207 (2d Cir. 1970), aff'd, 402 U.S. 991 (1971); Almenares v. Wyman, 334 F. Supp. 512, 518-19 (S.D.N.Y. 1971), modified, 453 F. 2d 1075 (2d Cir. 1972).

For all these reasons, the district court erred in refusing to certify this case as a class action.

CONCLUSION

For all of the foregoing reasons, the order and judgment of the district court should be reversed and remanded to the district court with instructions to enter summary judgment for plaintiffs and their class.

Respectfully submitted,

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AFFIDAVIT OF SERVICE BY MAIL

STATE OF NEW YORK)
: ss.:
COUNTY OF KINGS)

John C. Gray Jr being duly sworn, deposes and says:

That deponent is not a party to the action, is over 18 years of age and resides at 159 Bergen St. Brooklyn, N.Y.

That on the 14th day of June, 1976, deponent served the within brief of plaintiffs-appellants and parts of record below relied on by plaintiffs-appellants on each addressee listed below, being the address designated by said person for that purpose, by depositing a true copy of same enclosed in a postpaid properly addressed wrapper, in an official depository under the exclusive care and custody of the United States Post Office Department within New York State, addressed to:

1) Louis J. Lefkowitz.
Attorney General
2 World Trade Center
New York, N.Y.

2) W. Bernard Richland
Corporation Counsel
Municipal Building
New York, N.Y.

John C. Gray Jr.

Sworn to before me this
14th day of June, 1976

Margaret Zeigler
NOTARY PUBLIC

MARGARET ZEIGLER
Notary Public, State of New York
No. 24-4582895
Qualified in Kings County
Commission Expires March 30, 1977